DUNES DENTAL 4 Kids

Dr. Jeffrey Hemmingsen, DDS Dr. Jeffrey Howenstein, DMD, MS Dr. Kate Reeves, DDS

350 Oaktree Lane, Dakota Dunes, SD 57049 605-242-4700

Tell Us About Your Child

Today's Date:_____ Best Phone # to Reach You at: _____ ☐Mobile ☐ Home ☐ Work

Child's Name: _____ _____ _____ Child's Birthdate: _____ Child's Age: _____
First M.I. Last

Nickname: _____ ☐ Male ☐ Female School: _____ Grade: _____

Child's Home Address: _____
City State Zip

What patient or physician can we thank for referring you? _____

Parents' Information

Parent's Marital Status: ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Remarried ☐ Single ☐ Partnered

Mother Name:_____ _____ _____ Social Security #: _____
First M.I. Last

Birthdate: _____ Email Address: _____

Address: _____
City State Zip

Employer: _____

Home Phone #: _____ Work Phone #:_____ Cell Phone #: _____

Father Name: _____ _____ _____ Social Security # _____
First M.I. Last

Birthdate: _____ Email Address: _____

Address: _____
City State Zip

Employer: _____

Home Phone #: _____ Work Phone #: _____ Cell Phone #: _____

Insurance Information

Primary Insurance Dental Coverage: ☐ Yes ☐ No

Insured's Name: _____ _____ _____ Relationship to Patient: _____
First M.I. Last

Insured's Birthdate: _____Insured's ID #:_____ Insured's Employer: _____

Employer's Address: _____

Insurance Co. Name: _____ Phone #: _____ Group # (Plan, Local or Policy #): _____

Insurance Co. Address: _____

Secondary Insurance Dental Coverage? ☐ Yes ☐ No

Insured's Name: _____ _____ _____ Relationship to Patient: _____
First M.I. Last

Insured's Birthdate: _____Insured's ID #:_____ Insured's Employer: _____

Employer's Address: _____

Insurance Co. Name: _____ Phone #: _____ Group # (Plan, Local or Policy #): _____

Insurance Co. Address: _____

Dental History

Is the child currently in pain? ☐ Yes ☐No What is the primary reason for today's visit? _____

Has the child experienced problems with previous dental work? ☐ Yes ☐ No

Does the child brush his/her teeth daily? ☐ Yes ☐ No

Floss his/her teeth daily? ☐ Yes ☐ No

Has the child had sealants in the past? ☐ Yes ☐ No

What is the date of the last dental xray? ☐ Yes ☐ No

☐ Previous ☐ Present Dentist: _____ Date of Last Visit: _____

Why did you leave your previous dentist?: _____

What did you like most about any dentist you have seen?: _____

How do you think your child will do today?: _____

Does/did the child have any of the following habits?

☐ Yes ☐ No Lip Sucking/Biting	☐ Yes ☐ No Clenching/Grinding Teeth	☐ Yes ☐ No Tongue/Cheek Biting
☐ Yes ☐ No Mouth Breather	☐ Yes ☐ No Nail Biting	☐ Yes ☐ No Thumb/Finger Sucking
☐ Yes ☐ No Used Pacifier	☐ Yes ☐ No Speech Problems	☐ Yes ☐ No Chewing on Objects
☐ Yes ☐ No Nursing Bottle habits	☐ Yes No Tongue Thrust	☐ Yes ☐ No Breast Fed

Medical History

Child's Physician: _____ Phone #: _____ Date of Last Visit: _____

Address: _____

Is the child currently under the care of a physician? ☐ Yes ☐ No Please explain: _____

Please describe the child's current physical health: ☐ Good ☐ Fair ☐ Poor **Are immunizations current?** ☐ Yes ☐ No

Please list all of the drugs that the child is currently taking: _____

Is your child allergic to any of the following? ☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics ☐ Nut Allergy

Does your child have any medical conditions that require Pre-Med? ☐ Yes ☐ No

Has the child had/experienced any of the following:

☐ Yes ☐ No Abnormal Bleeding	☐ Yes ☐ No Down Syndrome	☐ Yes ☐ No Radiation Therapy
☐ Yes ☐ No Anemia	☐ Yes ☐ No Emotional/Psychiatric Problems	☐ Yes ☐ No Rheumatic Fever
☐ Yes ☐ No Any Hospital Stay/Operations	☐ Yes ☐ No Epilepsy	☐ Yes ☐ No Seizures
☐ Yes ☐ No Autism Spectrum	☐ Yes ☐ No Food Allergies	☐ Yes ☐ No Seasonal Allergies
☐ Yes ☐ No Birth Defects	☐ Yes ☐ No G-Tube Feeding	☐ Yes ☐ No Sickle Cell Anemia
☐ Yes ☐ No Blood Transfusions	☐ Yes ☐ No Hearing Loss/Impairment	☐ Yes ☐ No Skin Disorders
☐ Yes ☐ No Cancer	☐ Yes ☐ No Heart Condition/Murmur	☐ Yes ☐ No Sleep Apnea/Snoring
☐ Yes ☐ No Cerebral Palsy	☐ Yes ☐ No Hepatitis	☐ Yes ☐ No Spina Bifida
☐ Yes ☐ No Chronic Ear Infections/Tubes	☐ Yes ☐ No HIV/AIDS	☐ Yes ☐ No Tonsillitis
☐ Yes ☐ No Cystic Fibrosis	☐ Yes ☐ No Hyperactivity/ADHD	☐ Yes ☐ No Tuberculosis (TB)
☐ Yes ☐ No Delayed Speech Development	☐ Yes ☐ No Kidney Disease	☐ Yes ☐ No Tumors
☐Yes ☐ No Developmental Delay	☐ Yes ☐ No Learning Disability	☐ Yes ☐ No Syndrome (Specify)
☐ Yes ☐ No Diabetes	☐ Yes ☐ No Liver Disease	
☐ Yes ☐ No Asthma	☐ Yes ☐ No Muscular Dystrophy	

Please explain any Yes answers: _____

_____

Authorization

I affirm that the information I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary services that my child may need. I assign the Doctor to all insurance benefits. I understand that I am responsible for payment of services rendered, and deductible, and co-payment that my insurance does not cover.

Signature:_____ Date: _____